

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01705

Reg. Dist. No. 97

1708

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bainbridge</u>			c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Dead on Arrival at USNH, Bainbridge</u>				d. STREET ADDRESS <u>RD#1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>CAMERON</u> Last <u>ABRAMS</u>				4. DATE OF DEATH Month <u>February</u> Day <u>7</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-3-1899</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto Mechanic</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Navy</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>James W. ABRAMS</u>				14. MOTHER'S MAIDEN NAME <u>Mollie M. KIRK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>705 12 0158</u>		17. INFORMANT <u>Navy Records</u> Address _____			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R. C. DODSON</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>2-7-57</u>	
EXAMINER'S NAME (Type) <u>R. C. DODSON, M.D.</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
22b. DATE THEREOF <u>2/10/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bay View Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>North East, RD#1, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks, Elkton, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>2-7-57</u>		24b. REGISTRAR'S SIGNATURE <u>Dorothy B. Bramble</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be turned to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of medical examiner	
10. Signature of physician		11. Signature of coroner		12. Signature of registrar	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of hospital		17. Signature of nursing home		18. Signature of other institution	
19. Signature of other institution		20. Signature of other institution		21. Signature of other institution	
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100. Signature of other institution		101. Signature of other institution		102. Signature of other institution	

BUREAU V. S.

FEB 11 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 211 2-21-57 et

01706

1692

CERTIFICATE OF DEATH

Reg. Dist. No.

982

1. PLACE OF DEATH a. COUNTY <u>ecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>3 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u> <u>12.242</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Elkton Hosp.</u>				d. STREET ADDRESS <u>815 Otsego St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James Arthur Barnes</u>				4. DATE OF DEATH Month <u>2</u> Day <u>12</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 13-1892</u> <u>64</u> yrs.	
9. AGE (In years, lost birthday) <u>64</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pipe Fitter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Edgewood Chemicals</u>		11. BIRTHPLACE (State or foreign country) <u>Harford</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Geo. Washington Barnes</u>			
14. MOTHER'S MAIDEN NAME <u>Cornelia Dinmore</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>			
16. SOCIAL SECURITY NO. <u>Unknown</u>				17. INFORMANT <u>Mrs. Leona G. Barnes</u> Address <u>815 Otsego St. Harford, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>20 days</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>Jan 23</u> , 19 <u>57</u> , to <u>Feb 12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb 12</u> , 19 <u>57</u> , and that death occurred at <u>2:30</u> A. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>S. Ralph Andrews Jr.</u> M.D. <u>233 E. Main St. Elkton, Md.</u>				DATE SIGNED <u>2/12/57</u>			
PHYSICIAN'S NAME (Type) <u>S. RALPH ANDREWS JR. M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/15/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Harford</u> <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. H. Harrison</u> Address <u>Harford, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>2/13/57</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. H. Harrison</u>	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01707

1709

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>PENNSYLVANIA</u> b. COUNTY <u>Erie</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Point</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Erie</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Veterans Administration Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ARVID</u> Middle <u>PALMON</u> Last <u>BRANDT</u>		4. DATE OF DEATH Month <u>February</u> Day <u>21</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 14, 1895</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Motion Picture Oper.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Theatre</u>	
11. BIRTHPLACE (State or foreign country) <u>Sweden</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Hospital Records, VAH., Perry Point, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia bilateral unresolved</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Uremia, uremic poisoning (clinical)</u> DUE TO (c) <u>Nephrosclerosis bilateral</u> INTERVAL BETWEEN ONSET AND DEATH <u>7-10 days</u> <u>unknown</u> <u>unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u> </u> o. <u> </u> p. <u> </u> Month <u> </u> Day <u> </u> Year <u> </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 22, 19 30</u> , to <u>February 21, 19 57</u> , and that death occurred at <u>12:35 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>W. Oppler</u> M.D. <u>VAH., Perry Point, Md.</u> <u>2-25-57</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>W. OPPLER, M.D., Director, Professional Services, VAH., Perry Point, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>2-25-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Oppler</u>		24a. REC'D BY REGISTRAR DATE <u>2/27/57</u>	
ADDRESS <u>Bayre De Grace, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Irene E. Daugherty</u>	

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RECEIVED

CERTIFICATE OF DEATH

01708

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>KENT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESAPEAKE CITY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENTMORE PARK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MORGAN NURSING HOME</u>		d. STREET ADDRESS <u>14X02</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>J.</u> Last <u>COLGAIN</u>		4. DATE OF DEATH Month <u>FEB</u> Day <u>6</u> Year <u>1957</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 21, 1867</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>DEL.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>NEHEMIAH CLARK</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE E. LARRIMORE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS. WARREN JOHNSON</u>		Address <u>GALENA, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 446x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Nephrosclerosis</u> DUE TO (c) <u>Generalized arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>years</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 15</u> , 19 <u>57</u> , to <u>Feb 6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>FEB 6</u> , 19 <u>57</u> , and that death occurred at <u>8:00</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Cecilton, Md</u> DATE SIGNED <u>8 Feb 57</u>			
ACTUAL SIGNATURE <u>Wallace O'Brien</u> M.D.		PHYSICIAN'S NAME (Type) <u>WALLACE O'BRIEN</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2/9/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CHESTER CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>CHESTERTOWN, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Fellows</u>		24. REGISTRAR'S SIGNATURE <u>Mrs. Ralph A. Bess</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of health officer		17. Signature of coroner		18. Signature of jury	
19. Signature of medical examiner		20. Signature of pathologist		21. Signature of toxicologist	
22. Signature of bacteriologist		23. Signature of virologist		24. Signature of epidemiologist	
25. Signature of public health nurse		26. Signature of health visitor		27. Signature of social worker	
28. Signature of psychologist		29. Signature of psychiatrist		30. Signature of sociologist	
31. Signature of anthropologist		32. Signature of linguist		33. Signature of geographer	
34. Signature of historian		35. Signature of archaeologist		36. Signature of paleontologist	
37. Signature of numismatist		38. Signature of philologist		39. Signature of lexicographer	
40. Signature of grammarian		41. Signature of rhetorician		42. Signature of logician	
43. Signature of metaphysician		44. Signature of philosopher		45. Signature of theologian	
46. Signature of jurist		47. Signature of politician		48. Signature of statesman	
49. Signature of diplomat		50. Signature of ambassador		51. Signature of minister	
52. Signature of secretary of state		53. Signature of treasurer		54. Signature of comptroller	
55. Signature of auditor		56. Signature of clerk		57. Signature of stenographer	
58. Signature of typewriter		59. Signature of printer		60. Signature of publisher	
61. Signature of bookseller		62. Signature of stationer		63. Signature of optician	
64. Signature of pharmacist		65. Signature of druggist		66. Signature of chemist	
67. Signature of physicist		68. Signature of astronomer		69. Signature of meteorologist	
70. Signature of geologist		71. Signature of biologist		72. Signature of zoologist	
73. Signature of botanist		74. Signature of horticulturist		75. Signature of agriculturist	
76. Signature of forester		77. Signature of fisherman		78. Signature of hunter	
79. Signature of trapper		80. Signature of game warden		81. Signature of ranger	
82. Signature of park ranger		83. Signature of game warden		84. Signature of ranger	
85. Signature of game warden		86. Signature of ranger		87. Signature of ranger	
88. Signature of ranger		89. Signature of ranger		90. Signature of ranger	
91. Signature of ranger		92. Signature of ranger		93. Signature of ranger	
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100. Signature of ranger		101. Signature of ranger		102. Signature of ranger	

BUREAU V. 2

FEB 11 1957

RECEIVED

1693
CERTIFICATE OF DEATH

Reg. Dist. No. 97

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>CECIL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CECILTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X1 EARLEVILLE, RURAL</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>UNION HOSPITAL</u>		d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLARA</u> <u>EMMA</u> <u>CRAIG</u>		4. DATE OF DEATH Month Day Year <u>FEB</u> <u>27</u> <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 4, 1883</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>PETER HAGGERTY</u>		14. MOTHER'S MAIDEN NAME <u>ANNA MANNON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>ALBERT CRAIG</u>		Address <u>CECILTON, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Shock</u> DUE TO (c) <u>Acute Bronchial Asthma</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> <u>8 hours</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.0 Arteriosclerotic Heart Disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 1</u> , 19 <u>56</u> , to <u>27 Feb</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>27 Feb</u> , 19 <u>57</u> , and that death occurred at <u>8:52</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wallace Owenshain M.D.</u>		ADDRESS (Street, city or town, state) <u>Cecilton, Md</u> DATE SIGNED <u>1 Mar 57</u>	
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3/2/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BETHEL CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>CHESAPEAKE CITY MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Fellows</u>		ADDRESS <u>Millington, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE MAR 4 1957</u>		24b. REGISTRAR'S SIGNATURE <u>L. R. Hayes</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF CORONER	

BUREAU V. S.

MAR 2 1957

RECEIVED

CERTIFICATE OF DEATH

01710
Reg. Dist. No. 92

1. PLACE OF DEATH o. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elk Mills</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elk Mills</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Mattha</u> Middle <u>Emma</u> Last <u>Crookham</u>		4. DATE OF DEATH <u>February</u> Month <u>3</u> Day <u>57</u> Year <u>19</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 16, 1874</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ambrose Scotten</u>		14. MOTHER'S MAIDEN NAME <u>Martha Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>John W. Crookham,</u>		Address <u>Elk Mills, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chr. Interstitial Nephritis</u> <u>592X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Uremic Poisoning</u> DUE TO (c) <u>Hypertension</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u> <u>2 weeks</u> <u>3 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>General Debility</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct. 4, 1954</u> to <u>February 3, 1957</u> , that I last saw the deceased alive on <u>Feb. 1, 1957</u> , and that death occurred at <u>12:00</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>James L. Johnson</u> M.D. <u>February 14, 1957</u>		PHYSICIAN'S NAME (Type) <u>James L. Johnson M.D. Elkton, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-6-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cherry Hill Methodist Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Cherry Hill Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Grant</u>		ADDRESS <u>North East, Maryland</u>	24a. REC'D BY REGISTRAR DATE <u>Feb 14</u>
		24b. REGISTRAR'S SIGNATURE <u>J. R. Frazier</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FEB 5 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1712

CERTIFICATE OF DEATH

01711

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R.D. 4 EIKTON</u>		c. LENGTH OF STAY IN 1b <u>15 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X1 EIKTON, RURAL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>IRD#4</u>				d. STREET ADDRESS <u>IRD#4</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Verdie I. Crouse</u>				4. DATE OF DEATH Month Day Year <u>February 22 1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 2, 1877</u>	9. AGE (In years lost birthday) <u>79</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MAck COLLINS</u>				14. MOTHER'S MAIDEN NAME <u>JAMAMIA Shupe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>DAN CROUSE, CHATTHAM, Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GASTRO-INTESTINAL Hemorrhage</u> <u>445X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Malignant Hypertension</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June</u> , 19 <u>56</u> , to <u>22 Feb</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>21 Feb</u> , 19 <u>57</u> , and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George J. Kreis, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Elkton, Md</u>		DATE SIGNED <u>2/22/57</u>	
PHYSICIAN'S NAME (Type) <u>George J. Kreis, Jr.</u>				<u>EIKTON, MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Feb 26, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cherry Hill Meth Cen</u>		22d. LOCATION (City, town, or county) (State) <u>Cecil County, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks, 103, Stockton St, Elkton, Md</u>				24a. REC'D. BY REGISTRAR <u>2/25/57</u>		24b. REGISTRAR'S SIGNATURE <u>IR Frazier</u>	

MD STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

FEB 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01712

1713

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Ma. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun, Rural		c. LENGTH OF STAY IN 1b 5 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Graybeal Nursing Home				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Cecil Middle B Last Cummings				4. DATE OF DEATH Month Feb. Day 2 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 23, 1869		9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months 2 Days 2 Hours 7 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Liveryman		10b. KIND OF BUSINESS OR INDUSTRY Own Stables		11. BIRTHPLACE (State or foreign country) Pleasant Grove Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Henry Cummings				14. MOTHER'S MAIDEN NAME Margaret Thompson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT R.C. Dodson, Rising Sun, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inanition 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General Ateriosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-1-56 , 19 56 , to 1-30- 19 56 , (that I last saw the deceased alive on 1-28 , 19 57 , and that death occurred at 6 A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rising Sun, Md. DATE SIGNED							
ACTUAL SIGNATURE R.C. Dodson M.D.				PHYSICIAN'S NAME (Type) R.C. Dodson M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 5, 1957		22c. NAME OF CEMETERY OR CREMATORY West Nottingham		22d. LOCATION (City, town, or county) (State) Near Coloma Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Earl Tyson, Rising Sun Md. ADDRESS				24. REC'D BY REGISTRAR Feb 4-1-7		25. REGISTRAR'S SIGNATURE L. M. Thompson	

CERTIFICATE OF DEATH

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BUREAU V. S.

FEB 5 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01713

1694

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>CECIL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>21 ELKTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>UNION HOSP</u>		d. STREET ADDRESS <u>1 NORTH ST</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>NELLIE</u> Middle <u>EVR</u> Last <u>IS</u>		4. DATE OF DEATH Month <u>FEB</u> Day <u>13</u> Year <u>1957</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/17/1917</u>
9. AGE (In years last birthday) <u>39</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GENERAL</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Coleman</u>		14. MOTHER'S MAIDEN NAME <u>Mary Pierce</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>Union Hosp. Records, ELKTON, MD</u>	
17. INFORMANT Address <u>Union Hosp. Records, ELKTON, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cirrhosis of the liver</u> <u>581.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 29</u> , 19 <u>57</u> to <u>Feb 13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb 13</u> , 19 <u>57</u> , and that death occurred at <u>11:12 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>S. Ralph Andrews Jr.</u> M.D. <u>2.73 E Main St. Elkton, Md</u>		DATE SIGNED <u>2/14/57</u>	
PHYSICIAN'S NAME (Type) <u>S. RALPH ANDREWS JR. M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bury</u>		22b. DATE THEREOF <u>Feb 16, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Sunny Slope Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>West Point, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Henry Piggan</u> ADDRESS <u>Elkton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>2/15/57</u>	
24b. REGISTRAR'S SIGNATURE <u>J. H. Frazer</u>			

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1458 J. S. S.

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John C. ...

FEB 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01714

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3701-4 Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 707 Aisquith Street	
3. NAME OF DECEASED (Type or print) First JAMES Middle (NMI) Last FINCH		4. DATE OF DEATH Month February Day 16 Year 19 57	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 11, 1910
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Parking Lot Attendant		10b. KIND OF BUSINESS OR INDUSTRY Auto Parking Lot	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HARRY FINCH		14. MOTHER'S MAIDEN NAME MARY STONES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-II Unknown	
17. INFORMANT Address Hospital Records, VAH., Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia, bilateral, unresolved 138.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Uremia, uremic poisoning (Clinical) DUE TO (c) Sarcoidosis, generalized			INTERVAL BETWEEN ONSET AND DEATH 4 To 5 Days 6 To 8 Wks. Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 9, 19 57 to February 16, 19 57 , and that death occurred at 8:40 A.M. from the causes and on the date stated above. Signature W. Oppler ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 2-18-57			
ACTUAL SIGNATURE		M.D. W.A. Hospital, Perry Point, Md.	
PHYSICIAN'S NAME (Type) W. OPPLER		Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 2-17-57	
22c. NAME OF CEMETERY OR CREMATORY Sandy Level		22d. LOCATION (City, town, or county) (State) Bailey, North Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE PENNINGTON & SON		ADDRESS Harre DeGrace, Md.	
24a. REC'D BY REGISTRAR DATE 2-18-57		24b. REGISTRAR'S SIGNATURE Irene E. Dougherty	

BUREAU V. S.

FEB 20 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1695

CERTIFICATE OF DEATH

01715

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			c. LENGTH OF STAY IN 1b 3 Hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun Rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Helen Middle Sterling Last Foster				4. DATE OF DEATH Month Feb. Day 3 Year 1957				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 17, 1889		
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months 67 Days 67 Hours 67 Min.		IF UNDER 24 HRS. Months 67 Days 67 Hours 67 Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Rowlandville Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William Peeples				14. MOTHER'S MAIDEN NAME Hannah Rawlings				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Maynard Foster		Address Rising Sun, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Coronary DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 420.1 DUE TO (c) Acute Coronary							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-15-57 to 2-3-57 , 19 57 , that I last saw the deceased alive on 2-3-57 , 19 57 , and that death occurred at 7 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rising Sun, Md. DATE SIGNED 2-4-57								
ACTUAL SIGNATURE R. C. Dodson				M.D. Rising Sun, Md.				
PHYSICIAN'S NAME (Type) R. C. Dodson								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 7, 1957		22c. NAME OF CEMETERY OR CREMATORY Rosebank Cem.		22d. LOCATION (City, town, or county) (State) Near Rising Sun, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE J. Earl Tyson				ADDRESS Rising Sun Md		24a. REC'D BY REGISTRAR 2/5/57		
						24b. REGISTRAR'S SIGNATURE JR Trager		

1957 6 23

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01716

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

92

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton, R.D. 3</u>		c. LENGTH OF STAY IN 1b <u>20 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Elkton R.D. 3</u>	
4. NAME OF DECEASED (Type or print) First <u>Harold</u> Middle <u>Rivers</u> Last <u>Gray</u>		d. STREET ADDRESS <u>1 Andover</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-5-1897</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>24</u> Hours <u>19</u> Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>All kinds of work</u>	
11. BIRTHPLACE (State or foreign country) <u>Trainer, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry Rivers Gray</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs. Alice Gray, E. Main St. Elkton, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pistol shot above left Temple</u> DUE TO (b) <u>976X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Instantly</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>no</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self with a pistol</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>2-24-19</u> 5 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Elkton Cecil Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>R.C. Dodson</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>R.C. Dodson</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-4-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>North East Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>North East, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Henry Poffin</u>		ADDRESS <u>Elkton, Md.</u>	
24a. REC'D BY REGISTRAR <u>3/4/57</u>		24b. REGISTRAR'S SIGNATURE <u>JR. Frazer</u>	

MEDICAL CERTIFICATION

MAR 5 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01717

1696

CERTIFICATE OF DEATH

Reg. Dist. No.

92

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS 1 46 Hollingsworth Manor	
3. NAME OF DECEASED (Type or print) First Middle Last Boe Sirl Hamilton		4. DATE OF DEATH Month Day Year Feb 27 1957	
5. SEX 7	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 27
9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Elkton Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Warner J. Hamilton		14. MOTHER'S MAIDEN NAME Louise Martha Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Warner J. Hamilton		Address Elkton Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X Prematurity! DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 27, 1957, to Feb 27, 1957, that I last saw the deceased alive on Feb 27, 1957, and that death occurred at 4:12 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. H. S. Sprecher M.D.		DATE SIGNED Feb 28, 1957	
PHYSICIAN'S NAME (Type) M H Sprecher			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/28/57	
22c. NAME OF CEMETERY OR CREMATORY Cherry Hill Methodist Cem		22d. LOCATION (City, town, or county) (State) Cherry Hill Md	
23. FUNERAL DIRECTOR'S SIGNATURE 11 Walter duBois Jr. Elkton Md		24a. REC'D BY REGISTRAR DATE 2/28/57	
		24b. REGISTRAR'S SIGNATURE J H Frazier	

2065241XVO

CERTIFICATE OF DEATH

FILE NO.

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		45		M		W		1890		BALTIMORE		MD		MD		USA	
MARRIED		YES		NO		YES		NO		YES		NO		YES		NO	
OCCUPATION		FARMER		LABORER		MERCHANT		PROFESSOR		ARTIST		WRITER		OTHER		NONE	
CAUSE OF DEATH		HEART DISEASE		STROKE		CANCER		TUBERCULOSIS		PNEUMONIA		DIABETES		HYPERTENSION		OTHER	
DATE OF DEATH		MAY 10 1957		MAY 11 1957		MAY 12 1957		MAY 13 1957		MAY 14 1957		MAY 15 1957		MAY 16 1957		MAY 17 1957	
PLACE OF DEATH		HOME		HOSPITAL		NURSING HOME		PRISON		OTHER		NONE		NONE		NONE	
CITY OF DEATH		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
STATE OF DEATH		MD		MD		MD		MD		MD		MD		MD		MD	
COUNTRY OF DEATH		USA		USA		USA		USA		USA		USA		USA		USA	
DATE OF DEATH		MAY 10 1957		MAY 11 1957		MAY 12 1957		MAY 13 1957		MAY 14 1957		MAY 15 1957		MAY 16 1957		MAY 17 1957	
PLACE OF DEATH		HOME		HOSPITAL		NURSING HOME		PRISON		OTHER		NONE		NONE		NONE	
CITY OF DEATH		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
STATE OF DEATH		MD		MD		MD		MD		MD		MD		MD		MD	
COUNTRY OF DEATH		USA		USA		USA		USA		USA		USA		USA		USA	

BUREAU V. 2

MAR 4 1957

RECEIVED

1716

CERTIFICATE OF DEATH

Reg. Dist. No. 97

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CECIL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BAINBRIDGE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PORT DEPOSIT			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION NAVAL HOSPITAL, BAINBRIDGE, MARYLAND				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First RICHMOND Middle ALFRED Last HANCOCK JR.				4. DATE OF DEATH Month FEBRUARY Day 23 Year 1957			
5. SEX MALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 18 FEBRUARY 1957		9. AGE (In years last birthday) 5 Days	10. IF UNDER 1 YEAR Months 5 Days 5 Hours 5 Min. 5	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? UNITED STATES
13. FATHER'S NAME Richmond Alfred HANCOCK				14. MOTHER'S MAIDEN NAME Dorothy Eloise SPEAKE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT RICHMOND ALFRED HANCOCK		Address 18 A HENLEY PKWY., MANOR HEIGHTS	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ATELECTASIS 771.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CEREBRAL ANOXIA DUE TO (c) G. I. HEMORAGE, ETIOLOGY, UNDETERMINED							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 18, 1957 , to February 23, 1957 , that I last saw the deceased alive on February 23, 1957 , and that death occurred at 0759 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6B Henley Pkwy., Port Deposit, Maryland DATE SIGNED 23 FEB 1957							
ACTUAL SIGNATURE A. J. BISESE M.D.							
PHYSICIAN'S NAME (Type) A. J. BISESE							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 27 FEB 1957		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		22d. LOCATION (City, town, or county) (State) ARLINGTON VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son,				ADDRESS Perryville, Maryland		24a. REC'D BY REGISTRAR DATE 23 FEB 1957	
				24b. REGISTRAR'S SIGNATURE Dorothy B. Brumby			

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>				c. LENGTH OF STAY IN 1b <u>6 weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>				e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> NO <input type="checkbox"/> YES			
3. NAME OF DECEASED (Type or print) <u>Ethel</u> First <u>13.</u> Middle <u>Headly</u> Last				4. DATE OF DEATH <u>Feb</u> Month <u>22</u> Day <u>1957</u> Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 25 - 1893</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>			
11. BIRTHPLACE (State or foreign country) <u>Cumder N.J.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Fred G. Boelter</u>				14. MOTHER'S MAIDEN NAME <u>Lucy Kelly</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>SELF - Hospital Records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Snore -</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Amputation of Right Limb</u> DUE TO (c) <u>Diabetic Gangrene</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Indefinite</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan 1, 1957</u> to <u>Feb 22, 1957</u> , that I last saw the deceased alive on <u>Feb 22, 1957</u> , and that death occurred at <u>12:10 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H.A. Cantwell</u>				ADDRESS (Street, city or town, state) <u>North East Maryland</u>			
PHYSICIAN'S NAME (Type) <u>H.A. Cantwell</u>				DATE SIGNED <u>3/22/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Feb. 25, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cherry Hill Meth Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cecil County Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks, 103 Stockton St. Elkton</u>				24a. REC'D BY REGISTRAR <u>4/25/57</u>		24b. REGISTRAR'S SIGNATURE <u>JR Frazier</u>	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01720

1717

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore A.A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marley Park, Glen Burnie 02x22	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 31 Second Avenue	
3. NAME OF DECEASED (Type or print) First FRANK Middle (NMI) Last HOLUB		4. DATE OF DEATH Month February Day 7 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 20, 1893
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months 7 Days 19 Hours 57 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fressman		10b. KIND OF BUSINESS OR INDUSTRY Newspaper	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FRANK HOLUB		14. MOTHER'S MAIDEN NAME NELLIE TAXES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) Yes WW-I		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records, VAH., Perry Point, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema, Massive, Bilateral DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease, Severe DUE TO severe (c) Myocardial fibrosis, Arteriosclerosis, generalized.		INTERVAL BETWEEN ONSET AND DEATH 2-3 Hours Unknown Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from May 10, 1956 , to February 7, 1957 , and that death occurred at 1:05 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Perry Point, Maryland DATE SIGNED 2-10-57 ACTUAL SIGNATURE W. Oppler M.D. PHYSICIAN'S NAME (Type) W. OPPLER, M.D., Director, Professional Services, VAH., Perry Point, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 2-9-57	
22c. NAME OF CEMETERY OR CREMATORY Western Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Brinnington & Son		24a. REC'D BY REGISTRAR DATE 2/13/57	
ADDRESS Havre DeGrace, Md.		24b. REGISTRAR'S SIGNATURE Inez E. Daugherty	

CERTIFICATE OF DEATH

DECEASED		DATE OF DEATH	
NAME		AGE	
SEX		RACE	
MARRIAGE		EDUCATION	
OCCUPATION		RESIDENCE	
PLACE OF BIRTH		DATE OF BIRTH	
PLACE OF DEATH		DATE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		TIME	
PLACE		COUNTY	
STATE		FEDERAL BUREAU OF INVESTIGATION	
U.S. DEPARTMENT OF JUSTICE		WASHINGTON, D.C.	

BUREAU V. 2

2 15 1957

RECEIVED

State Department, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01721

1698

CERTIFICATE OF DEATH

Reg. Dist. No.

92

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CECIL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X1 FARLEVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>UNION HOSPITAL</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>DORA</u> Middle <u>-</u> Last <u>HURD</u>		4. DATE OF DEATH Month <u>FEB.</u> Day <u>25</u> Year <u>1957</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown 1894</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SAMUEL HURD</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA BAILEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mrs. Herman Hurd Farleville md.</u>		Address <u>Farleville md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA.</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>KIDNEY FAILURE. NEPHROSCLEROSIS</u> DUE TO (c) <u>3 years</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>GENERAL DEHYDRATION, ACIDOSIS, HEART FAILURE</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-23</u> , 19 <u>57</u> , to <u>2-25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2-25</u> , 19 <u>57</u> , and that death occurred at <u>3:00 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>OTTO Vogel</u> M.D.		ADDRESS (Street, city or town, state) <u>North East, MD</u>	
DATE SIGNED <u>2-25-57</u>			
PHYSICIAN'S NAME (Type) <u>OTTO VOGEL, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>FEB. 28, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CECILTON CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>CECILTON, CECIL CO., MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Holloway</u>		ADDRESS <u>Wilmington, Md</u>	
24a. REC'D BY REGISTRAR <u>DATE MAR 1 1957</u>		24b. REGISTRAR'S SIGNATURE <u>L. R. Frazier</u>	

RECEIVED
MAR 1 1957
BUREAU W. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1718

CERTIFICATE OF DEATH

01722

Reg. Dist. No. 94

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 North East</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Verla</u> First <u>Laird</u> Middle <u>Kline</u> Last		4. DATE OF DEATH <u>Feb 16</u> Month <u>16</u> Day <u>1957</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 9, 1900</u>
9. AGE (In years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walter Laird</u>		14. MOTHER'S MAIDEN NAME <u>Annie E. Lilley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-05-5260</u>	
17. INFORMANT <u>Frank W. Kline (husband)</u>		Address <u>North East, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Wira betes - Coma</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 24</u> , 19 <u>56</u> , to <u>Feb 16</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb 15</u> , 19 <u>57</u> , and that death occurred at <u>11 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>North East Md</u> DATE SIGNED <u>H. A. Cantwell</u>			
ACTUAL SIGNATURE <u>H. A. Cantwell</u> M.D.		PHYSICIAN'S NAME (Type) <u>H. A. Cantwell</u> <u>North East, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2-20-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Methodist</u>	22d. LOCATION (City, town, or county) (State) <u>North East Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Hunt</u> ADDRESS <u>North East Md</u>		24a. REC'D BY REGISTRAR DATE <u>2-20-57</u>	24b. REGISTRAR'S SIGNATURE <u>Sarah E. Rothermel</u>

BUREAU V. S.

FEB 25 1957

1954

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01723

1719

CERTIFICATE OF DEATH

Reg. Dist. No. 94

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X/ North East (Rural)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Matti T Laine				4. DATE OF DEATH Month Day Year February 25 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 8, 1892		9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Chicken		11. BIRTHPLACE (State or foreign country) Finland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Laine				14. MOTHER'S MAIDEN NAME Justiina Manumaa			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 264-22-8578		17. INFORMANT Mrs. Elsa M Laine		Address North East, Md., R.D.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of right lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. — 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) —		(County) (State)	
21. I certify that I attended the deceased from 10 Dec. 1956, to 25 Feb. 1957, that I last saw the deceased alive on 25 Feb. 1957, and that death occurred at 7:50 P.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) North East, Md.						DATE SIGNED	
ACTUAL PHYSICIAN'S NAME (Type) Klaus H. Huchner M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-28-57		22c. NAME OF CEMETERY OR CREMATORY North East Meth. Cemetery		22d. LOCATION (City, town, or county) (State) North East Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Shaw				ADDRESS North East, Md.		24a. REC'D BY REGISTRAR DATE 2-28-57	
				24b. REGISTRAR'S SIGNATURE Sarah E. Kothmel			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

BUREAU V. S.

MAR 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1699

CERTIFICATE OF DEATH

01724

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charlestown Post Office</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>		d. STREET ADDRESS <u>Charlestown, Maryland</u>	
3. NAME OF DECEASED (Type or print) <u>Benjamin K. Laughlin</u>		4. DATE OF DEATH <u>February 4 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 1, 1956</u>
9. AGE (In years last birthday) <u>3</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>.....</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Leon W. Laughlin</u>		14. MOTHER'S MAIDEN NAME <u>Betty King</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>.....</u>		16. SOCIAL SECURITY NO. <u>.....</u>	
17. INFORMANT <u>Leon W. Laughlin</u>		Address <u>Charlestown, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure (Cerebrating Colaps)</u> 571.0 DUE TO <u>Dehydration</u> 4/8 hours Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Infection - Pneumonia & Urinary</u> 3-4 days (c) <u>.....</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 28, 1957</u> to <u>Feb. 4, 1957</u> , that I last saw the deceased alive on <u>Feb. 4, 1957</u> , and that death occurred at <u>2:15 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George J. Kreis, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Elkton, Md.</u> DATE SIGNED <u>4 Feb. 1957</u>	
PHYSICIAN'S NAME (Type) <u>George J. Kreis, Jr.</u>		201 E. Main St., Elkton, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan 7, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oxford Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Oxford, Pennsylvania</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks</u>		24a. REC'D BY REGISTRAR <u>2/7/57</u>	
ADDRESS <u>103 Stockton Street, Elkton, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>FR J. J. J.</u>	

CERTIFICATE OF DEATH

MARY AND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

FEB 11 1957

RECEIVED

Reg. Dist. No. 95

1720

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15

BUREAU V. S.

MAR 5 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be far to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. Prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01727

Reg. Dist. No. 94

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Principio Furnace		c. LENGTH OF STAY IN 1b 49 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Principio Furnace			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. 15-RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle H. Last McDowell				4. DATE OF DEATH Month 2 Day 2 Year 19 57			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-24-1877		9. AGE (In years last birthday) 79 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY General		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William J. McDowell				14. MOTHER'S MAIDEN NAME Milchia Clark			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 212-16-8044		17. INFORMANT Address Rachel R. McDowell, Principio Fur. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 2-5-57		22c. NAME OF CEMETERY OR CREMATORY Principio Cemetery	
22d. LOCATION (City, town, or county) Principio Furnace				22e. (State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R Grant North East Md				24a. REC'D BY REGISTRAR DATE 2-4-57		24b. REGISTRAR'S SIGNATURE Sarah C. Kothermal	

MEDICAL CERTIFICATION

2

STATE OF TEXAS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Medical Examiner	
10. Signature of Coroner		11. Signature of Juror		12. Signature of Witness	
13. Signature of Physician		14. Signature of Nurse		15. Signature of Other	
16. Signature of Family		17. Signature of Friend		18. Signature of Other	
19. Signature of Other		20. Signature of Other		21. Signature of Other	
22. Signature of Other		23. Signature of Other		24. Signature of Other	
25. Signature of Other		26. Signature of Other		27. Signature of Other	
28. Signature of Other		29. Signature of Other		30. Signature of Other	
31. Signature of Other		32. Signature of Other		33. Signature of Other	
34. Signature of Other		35. Signature of Other		36. Signature of Other	
37. Signature of Other		38. Signature of Other		39. Signature of Other	
40. Signature of Other		41. Signature of Other		42. Signature of Other	
43. Signature of Other		44. Signature of Other		45. Signature of Other	
46. Signature of Other		47. Signature of Other		48. Signature of Other	
49. Signature of Other		50. Signature of Other		51. Signature of Other	
52. Signature of Other		53. Signature of Other		54. Signature of Other	
55. Signature of Other		56. Signature of Other		57. Signature of Other	
58. Signature of Other		59. Signature of Other		60. Signature of Other	
61. Signature of Other		62. Signature of Other		63. Signature of Other	
64. Signature of Other		65. Signature of Other		66. Signature of Other	
67. Signature of Other		68. Signature of Other		69. Signature of Other	
70. Signature of Other		71. Signature of Other		72. Signature of Other	
73. Signature of Other		74. Signature of Other		75. Signature of Other	
76. Signature of Other		77. Signature of Other		78. Signature of Other	
79. Signature of Other		80. Signature of Other		81. Signature of Other	
82. Signature of Other		83. Signature of Other		84. Signature of Other	
85. Signature of Other		86. Signature of Other		87. Signature of Other	
88. Signature of Other		89. Signature of Other		90. Signature of Other	
91. Signature of Other		92. Signature of Other		93. Signature of Other	
94. Signature of Other		95. Signature of Other		96. Signature of Other	
97. Signature of Other		98. Signature of Other		99. Signature of Other	
100. Signature of Other		101. Signature of Other		102. Signature of Other	

RECEIVED
FEB 6 1957
BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No.

1730

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Cecil Middle V. Last Moore				4. DATE OF DEATH Month February Day 24 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 18, 1900	
9. AGE (In years last birthday) yrs. 56		IF UNDER 1 YEAR Months 56 Days 56 Hours 56 Min. 56		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Paper Mfg Elk Paper Co.	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Theodore W. Moore				14. MOTHER'S MAIDEN NAME Anna McDowell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-03-0872		17. INFORMANT Address Mrs. Bertha B. Moore, R. D 3 Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Thrombosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5 hours 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 2/20 , 19 57 , to 2/24 , 19 57 , that I last saw the deceased alive on 2/23/57 , 19 57 , and that death occurred at 7:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 230 E Main St Elkton Md DATE SIGNED 2/25/57 ACTUAL SIGNATURE J Herbert Bates M.D. PHYSICIAN'S NAME (Type) J HERBERT BATES							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb 27, 1957		22c. NAME OF CEMETERY OR CREMATORY Cherry Hill Meth Cem.		22d. LOCATION (City, town, or county) (State) Cecil County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Nickl				ADDRESS 103 Stockton Street Elkton, Maryland		24a. REC'D BY REGISTRAR DATE 2/27/57	
24b. REGISTRAR'S SIGNATURE FR Trager							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is partially filled out with handwritten text.

BUREAU V. S.

FEB 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01729

1722

CERTIFICATE OF DEATH

Reg. Dist. No. 94

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Vera C. Nickle				4. DATE OF DEATH Month Day Year Feb. 27 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 16, 1883	9. AGE (In years last birthday) yrs. 73	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME George Guy B. Mackinson				14. MOTHER'S MAIDEN NAME Jennie Hahn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. --		17. INFORMANT Address Mrs. Cread F. Hyatt, North East, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 260X Myocardial Infarction DUE TO Uncontrolled diabetes mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none						INTERVAL BETWEEN ONSET AND DEATH 24 hours 12 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/26 1957, to 2/27 1957, that I last saw the deceased alive on 2/27 1957, and that death occurred at 3 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Neil Taylor M.D. Rising Sun, Md. 2/28/57 PHYSICIAN'S NAME (Type) Neil R Taylor Jr. Rising Sun, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 1, 1957		22c. NAME OF CEMETERY OR CREMATORY Methodist		22d. LOCATION (City, town, or county) (State) North East, Cecil Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Joseph P. Grant North East, Maryland.				24a. REC'D BY REGISTRAR DATE 2-28-57		24b. REGISTRAR'S SIGNATURE Sarah E. Kothermal	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01730

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

92

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton R.D.1		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 19 Elkton R.D.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Robin Adelia Rice		4. DATE OF DEATH Month 2 Day 5 Year 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-26-56
9. AGE (In years last birthday) yrs. 3		10. IF UNDER 1 YEAR Months 3 Days 9	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY Infant	
11. BIRTHPLACE (State or foreign country) Havre Grace, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter Leroy Rice		14. MOTHER'S MAIDEN NAME Maxine Leora Messenger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Address Walter Leroy Rice, Elkton, Md. R.D.1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9240 Smothered DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Down under covers and could not get air.	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 2 5 19 57 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Elkton		20g. (County) Cecil	
20h. (State) Md			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R.C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R.C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURNAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/7/57	
22c. NAME OF CEMETERY OR CREMATORY Gelpin Manor		22d. LOCATION (City, town, or county) Elkton	
22e. (State) Md			
23. FUNERAL DIRECTOR'S SIGNATURE W. Henry Pippin		24. REC'D BY REGISTRAR DATE 2/7/57	
24b. REGISTRAR'S SIGNATURE J.R. Frazer			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the file of the deceased.

TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2071181XV3

MASSACHUSETTS STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

FEB 11 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01731

CERTIFICATE OF DEATH

Reg. Dist. No.

96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Richmond 83x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 321 W. Grace	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MIDDLE Last ELLIS F. ROURKE		4. DATE OF DEATH Month February Day 19 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 20, 1908
9. AGE (In years lost birthday) yrs. 48		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY unknown	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Rourke		14. MOTHER'S MAIDEN NAME Annie Cole	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Bronchopneumonia, right lung, unresolved DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease, severe DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 102x Tuberculosis, pulmonary, left upper lobe - unknown		INTERVAL BETWEEN ONSET AND DEATH 5 days unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19 VA		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 28, 1949, to February 19, 1957, and that death occurred at 10:20a. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE W. OPLER		M.D. V.A. Hospital, Perry Point, Md. 2-20-57	
PHYSICIAN'S NAME (Type) W. OPLER		Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) removal		22b. DATE THEREOF 2-20-57	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.		24a. REC'D BY REGISTRAR DATE 2-21-57	
24b. REGISTRAR'S SIGNATURE Irene E. Dougherty			

BUREAU V. S.

FEB 25 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1725

CERTIFICATE OF DEATH

01732

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R. D. 1 Elkton, Md.		c. LENGTH OF STAY IN 1b 32 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R. D. 1 Elkton, Maryland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MICHAEL First SAFIA Last				4. DATE OF DEATH February Month 8 Day 19 Year 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 6, 1895		9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Crossing Watchman		10b. KIND OF BUSINESS OR INDUSTRY Penna. R. R.		11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Safia				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 716-01-7572		17. INFORMANT Address R. D. 1 Elkton, Md. Mrs. Josephine Safia (Wife)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocourdial Infarct (c) Pulmonary TB. (Diagnosis made John Hopkins)						INTERVAL BETWEEN ONSET AND DEATH 1 Day 8 mos. 5mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None - Operated on at John Hopkins - 3 weeks ago							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Oct. 19 56 , to Feb. 8 19 57 , that I last saw the deceased alive on Feb. 7 19 57 , and that death occurred at 5:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 202 E. Main St. Elkton, Md. DATE SIGNED Feb. 9-57							
ACTUAL SIGNATURE Jacob J. Greenwald M.D.							
PHYSICIAN'S NAME (Type) Jacob J. Greenwald, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb 12, 1957		22c. NAME OF CEMETERY OR CREMATORY Immaculate Conception		22d. LOCATION (City, town, or county) (State) Elkton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks				ADDRESS 103 Stockton Street Elkton, Maryland		24a. REC'D BY REGISTRAR DATE 2/12/57	
				24b. REGISTRAR'S SIGNATURE JR Frazee			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED John S. Smith</p>		<p>2. SEX Male</p>		<p>3. AGE 45</p>	
<p>4. DATE OF DEATH Jan 15, 1957</p>		<p>5. TIME OF DEATH 10:30 AM</p>		<p>6. PLACE OF DEATH Home</p>	
<p>7. CAUSE OF DEATH Myocardial Infarction</p>		<p>8. MANNER OF DEATH Natural</p>		<p>9. SIGNATURE OF PHYSICIAN J. S. Smith</p>	
<p>10. SIGNATURE OF REGISTRAR J. S. Smith</p>		<p>11. SIGNATURE OF DECEASED J. S. Smith</p>		<p>12. SIGNATURE OF WITNESSES J. S. Smith</p>	

BUREAU V. S.

FEB 13 1957

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1701

CERTIFICATE OF DEATH

01733

Reg. Dist. No. 92

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			c. LENGTH OF STAY IN 1b 10yrs.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 340 Hollingsworth Manor				d. STREET ADDRESS 340 Hollingsworth Manor			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Laura Belle Sanders				4. DATE OF DEATH Month Day Year Feb. 21 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/7/24	
9. AGE (In years last birthday) 32 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife			10b. KIND OF BUSINESS OR INDUSTRY Housekeeping			11. BIRTHPLACE (State or foreign country) Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Arter Hays				14. MOTHER'S MAIDEN NAME Dora Brooks			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 227-24-7247		17. INFORMANT Elton Sanders Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 174X Carcinoma of the uterus with metastase to lungs DUE TO (b) _____ DUE TO (c) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.							INTERVAL BETWEEN ONSET AND DEATH Over 10 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb. 18, 1957, to Feb. 21, 1957, that I last saw the deceased alive on Feb. 21, 1957, and that death occurred at 10 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE S. Ralph Andrews, Jr.				ADDRESS (Street, city or town, state) 233 E. Main St. Elkton, Md.		DATE SIGNED 2/21/57	
PHYSICIAN'S NAME (Type) S. RALPH ANDREWS, JR. M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/23/57		22c. NAME OF CEMETERY OR CREMATORY Elkton Cem.		22d. LOCATION (City, town, or county) (State) Elkton Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 4. Walter du Bose Jr Elkton Md				24a. REC'D BY REGISTRAR DATE 2/23/57		24b. REGISTRAR'S SIGNATURE JH Trager	

CERTIFICATE OF DEATH

1951

FEB 26 1957

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BUREAU V. 3

FEB 26 1957

BUREAU V. 3

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
SEX		RACE		EDUCATION	
MARRIAGE		OCCUPATION		CAUSE OF DEATH	
DATE OF DEATH		PLACE OF DEATH		MANNER OF DEATH	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE		PLACE OF SIGNATURE	
NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
SEX		RACE		EDUCATION	
MARRIAGE		OCCUPATION		CAUSE OF DEATH	
DATE OF DEATH		PLACE OF DEATH		MANNER OF DEATH	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE		PLACE OF SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1702

CERTIFICATE OF DEATH

01734

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton, Maryland			c. LENGTH OF STAY IN 1b 20 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton, 21		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS Cathedral Street 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last FRANK S. SCARBOROUGH				4. DATE OF DEATH Month Day Year February 10 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 18, 1909 47	
9. AGE (In years last birthday) 47 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant		10b. KIND OF BUSINESS OR INDUSTRY Service Station		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Mathew G. Scarborough				14. MOTHER'S MAIDEN NAME Margaret Gregg			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 216-05-3886		17. INFORMANT Address Josephine Scarborough, Elkton, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X Arteriosclerosis H.D.C. Congestive H.F. 5 days DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cirrhosis of Liver DUE TO (c) Diabetes Mellitus						INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 2-5, 1957, to 2-10, 1957, that I last saw the deceased alive on 2-10, 1957, and that death occurred at 7:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Sarah Fong Sung M.D. Union Hospital, Elkton, Md. 2-10-57 PHYSICIAN'S NAME (Type) Sarah Fong Sung, M.D. Union Hospital, Elkton, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb 13 1957		22c. NAME OF CEMETERY OR CREMATORY Sharps Cemetery		22d. LOCATION (City, town, or county) (State) Cecil County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks				ADDRESS 103 Stockton Street Elkton, Maryland		24a. REC'D BY REGISTRAR DATE 2/12/57	
				24b. REGISTRAR'S SIGNATURE J R J			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01735

Reg. Dist. No. 92

1703

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) SHEREE JEAN SIMPERS		4. DATE OF DEATH Month 2 Day 22 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 27, 1955
9. AGE (In years last birthday) 1 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Elkton, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert W. Simpners		14. MOTHER'S MAIDEN NAME Sarah E. Fears	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -	
17. INFORMANT Robert W. Simpners Father		Address North East, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 578X ADRENAL INSUFFICIENCY DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GASTRO INTESTINAL INFECTION DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 days 7 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CIRCULATORY FAILURE			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-17, 1957, to 2-22, 1957, that I last saw the deceased alive on 2-22-57, 19, and that death occurred at 6 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Otto Vogel M.D.		ADDRESS (Street, city or town, state) North East, Md.	
PHYSICIAN'S NAME (Type) OTTO VOGEL, M.D.		DATE SIGNED 2-23-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-24-57	
22c. NAME OF CEMETERY OR CREMATORY North East Methodist Cem.		22d. LOCATION (City, town, or county) (State) North East Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant		24a. REC'D BY REGISTRAR DATE 2/23/57	
		24b. REGISTRAR'S SIGNATURE J. R. Frazier	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 8 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1726

CERTIFICATE OF DEATH

Reg. Dist. No.

01736

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 9yrs.10mo.28days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 1105 Peach	
3. NAME OF DECEASED (Type or print) First OLIVER Middle T. Last SNOWDEN		4. DATE OF DEATH Month February Day 3 Year 19 57	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 20, 1895
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Snowden		14. MOTHER'S MAIDEN NAME Eliza (?)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give year or dates of service) WW I		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pyelonephritis, organism unknown 602X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Renal calculi, multiple, type unknown DUE TO (c) Bronchopneumonia, both lower lobes, unresolved		INTERVAL BETWEEN ONSET AND DEATH unknown unknown 7-10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Agensis of right kidney		(unknown)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 6 , 19 47 , to February 3 , 19 57 , and that death occurred at 9:35 a.m. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Oppler		DATE SIGNED 2-4-57	
PHYSICIAN'S NAME (Type) W. OPPLER		ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 2-4-57	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington ADDRESS Sancti Spiritus de Grace, Md.		24a. REC'D BY REGISTRAR Feb. 5 1957	
24b. REGISTRAR'S SIGNATURE Shane E. Wang			

CERTIFICATE OF DEATH

BUREAU V. 3

FEB 7 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01737

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE N. J. b. COUNTY CAMDEN	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CALVERT		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMDEN	
c. LENGTH OF STAY IN 1b 11 Mo.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GRAYBEALS NURSING HOME		d. STREET ADDRESS 67X-3	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First OTHNIEL Middle G Last STACKHOUSE		4. DATE OF DEATH Month FEB Day 6 Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 30, 1865
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY TALKING MACHINE	
11. BIRTHPLACE (State or foreign country) CAMDEN, N. J.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DAVID T. STACKHOUSE		14. MOTHER'S MAIDEN NAME MARGARET KERRIGEN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MIRIAM FOGG, NORTH EAST, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-1 , 19 56 to 2-6-57 , 19 57 , that I last saw the deceased alive on 2-5-57 , 19 57 , and that death occurred at 1P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE R. C. Dodson M.D.		ADDRESS (Street, city or town, state) Rising Sun, Md. DATE SIGNED 2-6-57	
PHYSICIAN'S NAME (Type) R. C. Dodson M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/8/57	
22c. NAME OF CEMETERY OR CREMATORY EVERGREEN		22d. LOCATION (City, town, or county) (State) CAMDEN N. J.	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph M Reed, Rising Sun, Md.		24. REC'D BY REGISTRAR Feb 7-57 24b. REGISTRAR'S SIGNATURE L. M. Whittington	

CERTIFICATE OF DEATH

REG. NO. 100

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		45		M		W		1882		BALTIMORE		MD		USA		USA	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY	
Carpenter		High School		Married		Catholic		Heart Disease		Natural		Feb 8 1957		Baltimore		MD	
Physician		Name		Address		City		State		Country		Date		Place		City	
Dr. J. H. Smith		123 Main St		Baltimore		MD		USA		USA		Feb 8 1957		Baltimore		MD	
Signature		Name		Address		City		State		Country		Date		Place		City	
Dr. J. H. Smith		123 Main St		Baltimore		MD		USA		USA		Feb 8 1957		Baltimore		MD	

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FEB 8 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01738

CERTIFICATE OF DEATH

Reg. Dist. No.

92

1704

1. PLACE OF DEATH o. COUNTY <i>Cecil</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Cecil</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elkton</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>North East</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Union Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Baby</i> Middle <i>Boy</i> Last <i>Stevens</i>				4. DATE OF DEATH Month <i>2</i> Day <i>4</i> Year <i>1957</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>2-3-1957</i>	
9. AGE (In years lost birthday) yrs. <i>4</i>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (State or foreign country) <i>Elkton Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				13. FATHER'S NAME <i>Wilbur Blakley</i>			
14. MOTHER'S MAIDEN NAME <i>Yvonne Stevens</i>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <i>Shady Stevens</i> Address <i>North East Md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Prematurity (1 lb. 33)</i> <i>761.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>(Premature Separation of Placenta)</i> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <i>10 hrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>-</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>-</i>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>- 19</i>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>-</i>	
20f. (City or town) <i>-</i> (County) <i>-</i> (State) <i>-</i>				21. I certify that I attended the deceased from <i>3 P.M.</i> , 1957, to <i>4 P.M.</i> , 1957, that I last saw the deceased alive on <i>4 P.M.</i> , 1957, and that death occurred at <i>7:30 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Klaus H. Huchner</i> M.D.				ADDRESS (Street, city or town, state) <i>No. 14 E. St., 2nd</i> DATE SIGNED <i>4-8-57</i>			
PHYSICIAN'S NAME (Type) <i>Klaus H. Huchner M.D.</i>				No. 14 E. St., 2nd			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2-4-1957</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Methodist</i>		22d. LOCATION (City, town, or county) (State) <i>North East Cecil Co. Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph R. Blank</i> ADDRESS <i>North East, Md</i>				24a. REC'D BY REGISTRAR DATE <i>2/4/57</i>		24b. REGISTRAR'S SIGNATURE <i>JR Frazer</i>	

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RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1705

CERTIFICATE OF DEATH

01739

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 218 E. Main St.		d. STREET ADDRESS 218 E. Main St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Lillian Alexander Sykes		4. DATE OF DEATH Month Day Year February 19 1957	
5. SEX F	6. COLOR OR RACE Wh	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 23, 1872
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY House Work	
11. BIRTHPLACE (State or foreign country) Elkton, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John E. Alexander		14. MOTHER'S MAIDEN NAME Martha J. Robinson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. G. Leslie Timme.		Address Abington, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio vascular renal DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid Arthritis			INTERVAL BETWEEN ONSET AND DEATH 1 day 10 years
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 11-10 19-53		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Elkton (County) Cecil (State) Md	
21. I certify that I attended the deceased from 2/19 to 2/19, 1957, that I last saw the deceased alive on 2/19, 1957, and that death occurred at 8 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. Herbert Bates		ADDRESS (Street, city or town, state) Elkton Md	
PHYSICIAN'S NAME (Type) J. HERBERT BATES		DATE SIGNED 2/20/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-22-1957	
22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		22d. LOCATION (City, town, or county) (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Phipps		24a. REC'D BY REGISTRAR DATE 2/23/57	
24b. REGISTRAR'S SIGNATURE J. R. Trager			

CERTIFICATE OF DEATH

1957

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>	
<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>		<p>9. PLACE OF DEATH</p>		<p>10. TIME OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>		<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF DECEASED</p>		<p>15. SIGNATURE OF NEXT OF KIN</p>	
<p>16. SIGNATURE OF DECEASED</p>		<p>17. SIGNATURE OF NEXT OF KIN</p>		<p>18. SIGNATURE OF DECEASED</p>		<p>19. SIGNATURE OF NEXT OF KIN</p>		<p>20. SIGNATURE OF DECEASED</p>	
<p>21. SIGNATURE OF NEXT OF KIN</p>		<p>22. SIGNATURE OF DECEASED</p>		<p>23. SIGNATURE OF NEXT OF KIN</p>		<p>24. SIGNATURE OF DECEASED</p>		<p>25. SIGNATURE OF NEXT OF KIN</p>	
<p>26. SIGNATURE OF DECEASED</p>		<p>27. SIGNATURE OF NEXT OF KIN</p>		<p>28. SIGNATURE OF DECEASED</p>		<p>29. SIGNATURE OF NEXT OF KIN</p>		<p>30. SIGNATURE OF DECEASED</p>	
<p>31. SIGNATURE OF NEXT OF KIN</p>		<p>32. SIGNATURE OF DECEASED</p>		<p>33. SIGNATURE OF NEXT OF KIN</p>		<p>34. SIGNATURE OF DECEASED</p>		<p>35. SIGNATURE OF NEXT OF KIN</p>	
<p>36. SIGNATURE OF DECEASED</p>		<p>37. SIGNATURE OF NEXT OF KIN</p>		<p>38. SIGNATURE OF DECEASED</p>		<p>39. SIGNATURE OF NEXT OF KIN</p>		<p>40. SIGNATURE OF DECEASED</p>	
<p>41. SIGNATURE OF NEXT OF KIN</p>		<p>42. SIGNATURE OF DECEASED</p>		<p>43. SIGNATURE OF NEXT OF KIN</p>		<p>44. SIGNATURE OF DECEASED</p>		<p>45. SIGNATURE OF NEXT OF KIN</p>	
<p>46. SIGNATURE OF DECEASED</p>		<p>47. SIGNATURE OF NEXT OF KIN</p>		<p>48. SIGNATURE OF DECEASED</p>		<p>49. SIGNATURE OF NEXT OF KIN</p>		<p>50. SIGNATURE OF DECEASED</p>	
<p>51. SIGNATURE OF NEXT OF KIN</p>		<p>52. SIGNATURE OF DECEASED</p>		<p>53. SIGNATURE OF NEXT OF KIN</p>		<p>54. SIGNATURE OF DECEASED</p>		<p>55. SIGNATURE OF NEXT OF KIN</p>	
<p>56. SIGNATURE OF DECEASED</p>		<p>57. SIGNATURE OF NEXT OF KIN</p>		<p>58. SIGNATURE OF DECEASED</p>		<p>59. SIGNATURE OF NEXT OF KIN</p>		<p>60. SIGNATURE OF DECEASED</p>	
<p>61. SIGNATURE OF NEXT OF KIN</p>		<p>62. SIGNATURE OF DECEASED</p>		<p>63. SIGNATURE OF NEXT OF KIN</p>		<p>64. SIGNATURE OF DECEASED</p>		<p>65. SIGNATURE OF NEXT OF KIN</p>	
<p>66. SIGNATURE OF DECEASED</p>		<p>67. SIGNATURE OF NEXT OF KIN</p>		<p>68. SIGNATURE OF DECEASED</p>		<p>69. SIGNATURE OF NEXT OF KIN</p>		<p>70. SIGNATURE OF DECEASED</p>	
<p>71. SIGNATURE OF NEXT OF KIN</p>		<p>72. SIGNATURE OF DECEASED</p>		<p>73. SIGNATURE OF NEXT OF KIN</p>		<p>74. SIGNATURE OF DECEASED</p>		<p>75. SIGNATURE OF NEXT OF KIN</p>	
<p>76. SIGNATURE OF DECEASED</p>		<p>77. SIGNATURE OF NEXT OF KIN</p>		<p>78. SIGNATURE OF DECEASED</p>		<p>79. SIGNATURE OF NEXT OF KIN</p>		<p>80. SIGNATURE OF DECEASED</p>	
<p>81. SIGNATURE OF NEXT OF KIN</p>		<p>82. SIGNATURE OF DECEASED</p>		<p>83. SIGNATURE OF NEXT OF KIN</p>		<p>84. SIGNATURE OF DECEASED</p>		<p>85. SIGNATURE OF NEXT OF KIN</p>	
<p>86. SIGNATURE OF DECEASED</p>		<p>87. SIGNATURE OF NEXT OF KIN</p>		<p>88. SIGNATURE OF DECEASED</p>		<p>89. SIGNATURE OF NEXT OF KIN</p>		<p>90. SIGNATURE OF DECEASED</p>	
<p>91. SIGNATURE OF NEXT OF KIN</p>		<p>92. SIGNATURE OF DECEASED</p>		<p>93. SIGNATURE OF NEXT OF KIN</p>		<p>94. SIGNATURE OF DECEASED</p>		<p>95. SIGNATURE OF NEXT OF KIN</p>	
<p>96. SIGNATURE OF DECEASED</p>		<p>97. SIGNATURE OF NEXT OF KIN</p>		<p>98. SIGNATURE OF DECEASED</p>		<p>99. SIGNATURE OF NEXT OF KIN</p>		<p>100. SIGNATURE OF DECEASED</p>	

BUREAU V. S.

FEB 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01740

1728

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point			c. LENGTH OF STAY IN 1b 3mo. 27days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3 Washington		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 1735 Park Road, N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RAYMOND Middle P. Last TALBOTT				4. DATE OF DEATH Month February Day 12 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-8-95	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months 12 Days 19 Hours 57 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Hotel	
11. BIRTHPLACE (State or foreign country) Kansas				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Thomas O. Talbott - deceased				14. MOTHER'S MAIDEN NAME Mary E. Hardesty - deceased			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WWII		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of liver 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 1. p. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 16, 1956 , to February 12, 1957 , and that death occurred at 12:55 a.m. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. Oppler				ADDRESS (Street, city or town, state) M.D. V.A. Hospital, Perry Point, Md. DATE SIGNED 2-14-57			
PHYSICIAN'S NAME (Type) W. OPPLER				Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL Removal		22b. DATE THEREOF 2-14-57		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son				ADDRESS Havre de Grace, Md.		24a. REC'D BY REGISTRAR DATE 2/15/57	
				24b. REGISTRAR'S SIGNATURE Ernest E. Wengert			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. DATE OF DEATH		7. PLACE OF BIRTH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
JOHN J. JONES		M		45		W		JAN 15 1900		JAN 18 1957		BALTIMORE, MD		BALTIMORE, MD		HEART DISEASE		NATURAL		J. J. JONES		J. J. JONES	
13. OCCUPATION		14. EDUCATION		15. RELIGION		16. MARITAL STATUS		17. PREVIOUS ILLNESS		18. PREVIOUS SURGERY		19. PREVIOUS TRAUMA		20. PREVIOUS DRUGS		21. PREVIOUS ALCOHOL		22. PREVIOUS TOBACCO		23. PREVIOUS OTHER		24. PREVIOUS OTHER	
None		None		None		Married		None		None		None		None		None		None		None		None	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF WITNESS		27. SIGNATURE OF PHYSICIAN		28. SIGNATURE OF REGISTRAR		29. SIGNATURE OF PHYSICIAN		30. SIGNATURE OF REGISTRAR		31. SIGNATURE OF PHYSICIAN		32. SIGNATURE OF REGISTRAR		33. SIGNATURE OF PHYSICIAN		34. SIGNATURE OF REGISTRAR		35. SIGNATURE OF PHYSICIAN		36. SIGNATURE OF REGISTRAR	

RECEIVED
FEB 19 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01741

1706

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>192 E Main St.</u>				d. STREET ADDRESS <u>192 E Main St</u>			
3. NAME OF DECEASED (Type or print) First <u>Marion</u> Middle <u>J</u> Last <u>Thompson</u>				4. DATE OF DEATH Month <u>February</u> Day <u>28</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 16, 1879</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Salesman</u>		11. BIRTHPLACE (State or foreign country) <u>Stromstown, Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew J. Thompson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Chambers Hartsock</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-03-0600</u>		17. INFORMANT <u>Mrs. M. J. Thompson</u>		Address <u>192 E. Main St. ELKTON, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>443x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive arteriosclerotic cardiovascular disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>Several years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19 <u>57</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 14, 1953</u> , to <u>Feb. 28, 1957</u> , that I last saw the deceased alive on <u>Feb. 27, 1957</u> , and that death occurred at <u>4 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>S. Ralph Andrews, Jr.</u>				ADDRESS (Street, city or town, state) <u>231 E. Main St. Elkton, Md.</u>		DATE SIGNED <u>3/1/57</u>	
PHYSICIAN'S NAME (Type) <u>S. RALPH ANDREWS JR</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-3-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Friends Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Calvert Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Henry [illegible] Elkton, Md.</u>				24a. REC'D BY REGISTRAR <u>3/1/57</u>		24b. REGISTRAR'S SIGNATURE <u>FR [illegible]</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. DATE OF DEATH	
7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. MEDICAL HISTORY		11. PRESENT ILLNESS		12. TREATMENT	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF DECEASED	
16. SIGNATURE OF WITNESSES		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF BURIAL PLACE	
19. SIGNATURE OF CORONER		20. SIGNATURE OF JURY		21. SIGNATURE OF COURT	
22. SIGNATURE OF STATE DEPARTMENT OF HEALTH		23. SIGNATURE OF BALTIMORE CITY		24. SIGNATURE OF COUNTY	
25. SIGNATURE OF DISTRICT		26. SIGNATURE OF WARD		27. SIGNATURE OF BLOCK	
28. SIGNATURE OF LOT		29. SIGNATURE OF INTERMENT		30. SIGNATURE OF BURIAL	
31. SIGNATURE OF CREMATION		32. SIGNATURE OF OTHER		33. SIGNATURE OF REMAINS	
34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER	
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97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER	
100. SIGNATURE OF OTHER		101. SIGNATURE OF OTHER		102. SIGNATURE OF OTHER	

RECEIVED

BUREAU V. S.

MAR 5 1957

1729

CERTIFICATE OF DEATH

01742

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 7 mo. 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle J. Last WOELFEL JR.		4. DATE OF DEATH Month February Day 12 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-29-96
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months 12 Days 12 Hours 57 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Payroll	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William J. Woelfel, Sr.		14. MOTHER'S MAIDEN NAME Mary McDevitt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial fibrosis, left ventricle 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease, severe DUE TO (c) Arteriosclerosis, general, severe			
INTERVAL BETWEEN ONSET AND DEATH unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from July 10, 1956 , to February 12, 1957 , and that death occurred at 7:45 a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 2-12-57			
ACTUAL SIGNATURE W. Oppler		M.D. Director, Professional Services	
PHYSICIAN'S NAME (Type) W. Oppler			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 2-12-57	22c. NAME OF CEMETERY OR CREMATORY Baltimore National	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE John Burns'Sons, 610-612 York Rd. Towson, Md.		24a. REC'D BY REGISTRAR DATE 2/15/57	
		24b. REGISTRAR'S SIGNATURE Irene Daugherty	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01743

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City x2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Carrie Potter Wright				4. DATE OF DEATH February 3 1957			
5. SEX F		6. COLOR OR RACE Wh		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 29, 1877	
				9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home				10b. KIND OF BUSINESS OR INDUSTRY House Work		11. BIRTHPLACE (State or foreign country) Cambridge Md.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Thomas H. Wright				14. MOTHER'S MAIDEN NAME Margaret Keen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Berkley Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 day 5 yrs.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb 2, 1957, to Feb 3, 1957, that I last saw the deceased alive on Feb 3, 1957, and that death occurred at 11:30 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE J. HERBERT BATES				ADDRESS (Street, city or town, state) Elkton Md		DATE SIGNED Feb 4-57	
PHYSICIAN'S NAME (Type) J. HERBERT BATES							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 2-6-1957		22c. NAME OF CEMETERY OR CREMATORY St. Roses Catholic	
22d. LOCATION (City, town, or county) Chesapeake City				(State) Md.			
23. GENERAL DIRECTOR'S SIGNATURE				ADDRESS Elkton, Md.		24a. REC'D BY REGISTRAR DATE 2/7/57	
				24b. REGISTRAR'S SIGNATURE		FR Frazier	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

FILE NO.

DATE OF DEATH

PLACE OF DEATH

SEX

AGE

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

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